Cross-Cultural Communication Issues:
Children with Special Health Care Needs

An Annotated Bibliography

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for Southwest Communication Resources

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Introduction

> *One of the challenges for service providers is to locate the family within its own story, the dramatic sequence that tells us where they have been, and where they see themselves going. It is within their story, as much as they are willing to share it, and to the extent we are willing to really hear it, that we will truly begin to build a partnership with the family . . .* (Jones, 1994)

This annotated bibliography was developed as part of a three-year project, known as the OPUS Project. The purpose of the project was to improve cross-cultural communication and collaboration between professionals and families whose children have special health care needs. To learn more about cross-cultural communication issues in human services fields the project conducted a comprehensive search of the literature. This document represents the results of that search. It includes a representative selection of writings addressing cross-cultural communication issues.

The literature on cultural differences between ethnic groups is extensive. Therefore, a hierarchy of preferences was developed. Selections were chosen because of their specific focus on communication. Within the literature on cross-cultural communication, preference was given to studies involving families of children with special health care needs and the delivery of health care services. Studies dealing with education were included if they offered important insights that were transferable to health care. Within the parameters of the criteria selected, the reader will find a variety of thought provoking studies with new and varied perspectives.

About the Authors

David Allen Jones has worked for many years helping local, state and national agencies to better serve children with special needs from diverse communities. He was the director for the WINGS Project, assisting eleven American Indian tribes in Wisconsin to identify and find service for Indian children with special needs.

Mr. Jones has also served as a consultant to the Wisconsin MCH Program for Children with Special Health Care Needs, assisting them to develop a statewide needs assessment process involving families, local agency staff and state personnel. He has contributed to a number of publications, including *Essential Allies: Families as Advisors* (Jeppson and Thomas, 1995); *Family-Centered Care for Children with Specialized Health and Developmental Services* (Shelton & Stepanek, 1994); *Caring for Children and Families: Guidelines for Hospitals* (Johnson, Jeppson, & Redburn, 1992); *Fathers of Children with Special Needs: New Horizons* (May, 1991).

Randi S. Malach has a Master of Clinical Science in Communication Disorders. She has worked for over 20 years in field of speech-language pathology. She served as the project director for several HRSA Maternal and Child Health SPRANS grants addressing cross-cultural communication issues between families of children with special health care needs and service providers. Ms. Malach has developed audiovisual and other curriculum materials to be used in preservice and inservice training programs. She is currently the Director of Program Services for a community-based early intervention organization in New Mexico. Ms. Malach has contributed to several publications including, *Culturally Responsive Services for Children and Families: A Training Manual* (Southwest Communication Resources, 1993); *Developing Cross-Cultural Competence* (Lynch & Hanson, 1992); *Perspectives on Health Care Delivery Systems for American Indian Families* (Malach & Segel, 1990).

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Articles, Chapters, Books

Anderson, J. M. (1986). Ethnicity and illness experience: Ideological structures and the health care delivery system. *Social Science and Medicine, 22*(11), 1277-1283.

This essay approaches issues in communication between health care practitioners and patient families as problems of ideology. Specifically, the author focuses on the structured set of beliefs, attitudes, and behaviors formalized as the North American (in this case Canadian) health care system. Her arguments are based on a study of Chinese immigrant families caring for chronically ill or disabled children. These families were compared with white Anglo-Canadian middle-class families, in the way they interacted with and understood the established medical care system in Canada. The author asserts that there is an implicit understanding between fully acculturated families and health care professionals. Each acknowledges both the hierarchy of the system and its assumptions about care. These assumptions include the idea that children with special needs are to be "normalized." This means that families are expected to treat their children as “normal” and ignore the obvious fact that they receive extended therapies, treatments, surgeries, etc. The author argues that communication and understanding break down with new immigrants because they do not share the same normative assumptions about their children. These newly arrived families may believe in simply caring for their children as they are. These families may not share the health care system value of assertive intervention.

Berlin, E. A., & Fowkes, W. C. (1983, December). A teaching framework for cross-cultural health care: Application in family practice. *The Western Journal of Medicine, 139* (6), 934-938.

While many authors approach problems of clinical provider/family interaction by discussing specific cultural differences, the authors of this article concentrate explicitly on the communication process. Their aim is to teach family medicine residents an easy-to-remember framework for eliciting and conveying correct information in a way that is sensitive, simple, and straightforward. They developed a set of guidelines structured in a mnemonic framework -- the **LEARN** model.

L - “*Listen* with sympathy and understanding to the patient's perception of the problem”;

E - “*Explain* your perceptions of the problem”;

A - “*Acknowledge* and discuss the differences and similarities”;

R - “*Recommend* treatment”; and

N - "*Negotiate* agreement."
Each of these guidelines is explained and discussed. Then the reader is taken through the entire process using actual case examples. Each example describes the individuals and their presenting histories, and closes with a discussion of their "cultural context."

Council for Exceptional Children (1991, May). Communicating with culturally diverse parents of exceptional children. *ERIC Digest (#E497)*.

This bulletin is addressed to providers who must communicate the finding of a disability to a child's family, when that family is one of the growing number of diverse ethnic groups that makes up the population of the United States. The authors point out that feelings are expressed differently across cultures, "especially disappointment, anxiety, fear, embarrassment, and anger." Therefore, it may not always be easy to discern the emotional reactions of the family. During face-to-face interactions they suggest "courtesy, sincerity, and ample opportunity and time to convey concerns . . ." To facilitate written communication, the authors suggest providing information in the family's native language and using the appropriate reading level. Providers are reminded that parents may feel many stresses "as they attempt to sort out facts from their fundamental beliefs . . ." With the caveat that some of the literature reinforces existing stereotypes, the authors offer some general guidelines to cross-cultural interactions. These guidelines are grouped under the headings: **Sharing space, Touching, Eye contact,** and **Time ordering of interactions.** Providers are encouraged to support families as they learn how to participate in the health care system.

Cowley, G., & Picker, L. (1990, September 24). Does doctor know best? Overriding the family. *Newsweek*, p. 84.

This short article in *Newsweek* magazine presents a stark picture of what can happen when parent advocacy and cultural beliefs collide with the social and political power of the mainstream health care system. Juliet Cheng was assertive in seeking help for her daughter, Shirley, who suffers from severe juvenile rheumatoid arthritis. This mother sought out and used both Western and Eastern (Chinese) medical treatments. However, Shirley continued to suffer pain and progressive loss of movement. Her American physician finally proposed surgery to repair her joints. Ms. Cheng rejected his advice. She decided to make another trip to China to try less extensive surgery in conjunction with traditional Chinese treatments. Before she could act, Shirley was seized by the state and placed in the custody of the hospital. Questions are raised about who has the "best interests" of the child in mind, and how families are affected when courts decide against the parents. The article cites the case of a California court authorizing surgery to correct a 6-year-old Hmong child's club feet, over the "profound religious objections" of the family. Also cited is a 1987 study which found that in 86 percent of recorded cases, judges sided with doctors who wanted to intervene to assist a fetus despite a woman's objections. Eighty percent of the resulting

Caesarean operations were performed on Black or Asian patients.

Crisp, A. H., & Edwards, W. J. (1989). Communication in medical practice across ethnic boundaries. *Postgraduate Medical Journal, 65,* 150-155.

Although this article from the United Kingdom is aimed primarily at the pre-service and in-service training of physicians, its relevance to the broader health care and human services community is apparent. The authors' hypothesis is that communication in the therapeutic setting is "in many senses unnatural . . . and has to be learned by most of us." Whether the reader accepts this statement or not, useful reflections on the problems of clinical communication are presented. Some observations by the authors: "Good communication requires time. It also calls for understanding by the doctor of his or her own temperament." "Languages reflect cultures and do not necessarily lend themselves to absolute translation and reduction to common meanings." The authors append their article with a detailed curricular outline for training physicians in clinical communication.

Section One:	**Basic clinical communication**
Section Two:	**Content of teaching** (including information on ways to relate to the patient, elicit information, and integrate information gathered)
Section Three:	**Educational process**
Section Four:	**Additional goals for doctors engaging in communication across ethnic boundaries**

Douglis, C. (1987, November). The beat goes on: Social rhythms underlie all our speech and actions. *P*

s y c h o l o g y T o d a y , *2 1* , 3 6 - 4 2 .

We are introduced here to the new field of research on subconscious, interpersonal rhythms. Researchers claim that this "rhythmic synchrony" begins even before birth, as the developing fetus and its mother synchronize their heartbeats, movements, and utterances. As we grow into social beings, the "beat" of language and the correlated "dance" of body movements signal interpersonal connectedness or attention, and even group cohesiveness. This new knowledge has implications for the inter-cultural communication between health care providers and families. Providers and families may unconsciously discover that they have two disparate rhythmic backgrounds. "When speakers and listeners come from different cultures . . . they often have widely differing rhythmic expectations. . . . A foreigner, for instance, may stress words other than key ones for which you may be listening." Soon the dance of interaction begins to fall apart, and there is discomfort on both sides. These rhythms exist not just in the active phase of communication, but in its pauses. "When people hold differing expectations of pause length -- the amount of time one waits before speaking after someone else stops talking -- trouble can occur." Researchers hope that in the future people will be able to "improve the way they talk to people of other cultures by investing a few hours in learning about cultural rhythms."

Goode, E. E. (1993, February 15). The cultures of illness: Health care professionals learn to appreciate immigrants' beliefs. *U.S. News & World Report, 114*(6), 74-

76.

This article calls attention to the changing face of the nation's health care user. The swelling immigrant population brings its multi-cultural beliefs and many languages into the clinic and hospital. The author uses many colorful scenarios, some with tragic endings, to illustrate how health care providers must now be more flexible and creative as they sort out medical histories. Their task can be further complicated by language differences, the use of interpreters, and unfamiliar cultural beliefs. Also discussed are the broader, deeper needs of political refugees. Many refugees have endured not only great physical suffering, but also deep psychological traumas. The practitioner must be prepared to help the individual deal with spiritual, and at times deeply personal, injuries. This sometimes means looking for assistance from the individual own culture, such as in the use of a Buddhist priest, a shaman, or a Chinese herbalist. Health care providers are challenged to bring to the therapeutic relationship a sense of wonder, curiosity, flexibility, and tolerance, "virtues that go far with any patient."

Gonzalez-Mena, J. (1992, January). Taking a culturally sensitive approach in infant-toddler programs. *Young Children, 47*(2), 4-9.

"The purpose of this article is to help care givers look at ways to improve sensitivity to cultural and individual differences and increase communication across cultural barriers." The article addresses what the author calls "conflict situations" by outlining four possible outcomes of these conflicts:

1. Resolution through understanding and negotiation:
   Both parties see the other's perspective--both parties compromise.
2. Resolution through care giver education:
   The care giver sees the parent's perspective--the care giver changes.
3. Resolution through parent education:
   The parent sees the care giver's perspective--the parent changes.
4. The fourth possible outcome is one not often addressed by other writers: Possible conflict *management* when conflict *resolution* seems impossible.

The author offers an excellent series of tips on "allowing cultural conflicts to rise and responding in a sensitive, respectful manner." These tips may be easily adapted to other fields in which the professional is searching for ways to*manage* conflict to enhance cross-cultural communication.

Gostin, L. O. (1995, September 13). Informed consent, cultural sensitivity, and respect for persons. *Journal of the American Medical Association, 274*(10), 844-845.

The topic of informed consent is rising in importance and interest in health care. This is no doubt due in part to the growing incidence and complexity of medical ethics problems. Examples include, ethical issues that arise in cases of the withdrawal of life support or extraordinary efforts to save premature infants. Recently, the literature is also addressing the nature of informed consent itself. Researchers are questioning whether it is a universally definable ideal or whether it is a culturally relative construct. This editorial proposes that the presently evolved concept of informed consent, although now almost universally accepted in official circles, is uniquely Western in its insistence on the absolute moral necessity of self-determination and the autonomy of the individual. The author weighs the benefits and harms of going too far in either direction. At one extreme there is no formalized framework for consent, which might lead back to medical paternalism. At the other extreme are the heavily legalistic approaches that frame the therapeutic relationship as a "bilateral contractual relationship." Independent ethical review is suggested for times when the clinician "has reason to believe that the patient has different cultural expectations of the therapeutic relationship."

Haffner, L. (1992, September). Translation is not enough: Interpreting in a medical setting. *The Western Journal of Medicine, 157*(3), 255-259.

Rather than the more usual analytical approach, this article written by a professional Spanish-language interpreter takes a day-in-the-life approach to medical interpretation. We are "on hospital rounds" with Linda Haffner, learning directly from her narrative of a typical day as she tries to "bridge the language, cultural, and knowledge gaps". Ms. Haffner shares her observations and discusses the many levels of interaction taking place in the triad of individual/family, interpreter, and clinician. This article is particularly rich in descriptions of the beliefs and behaviors of Spanish-speaking families, especially those recently immigrated from Central American or South American countries. As other authors, Ms. Haffner makes a strong case for not using family members, especially young children, for medical interpretation. She does encourage health care providers to learn even small amounts of other languages. They can use this knowledge for small talk to build a positive relationship with the individuals/families with whom they are working. Ms. Haffner does caution clinicians against getting in over one's head during clinical history-taking. She relates the case of a physician asking a Spanish-speaking female, "¿Cuántos*anos* tiene usted?" ("How many anuses do you have?") instead of "¿Cuántos*años* tiene usted?" ("How old are you?").

Harry, B. (1992). Communication, information, and meaning (Chapter 8). *Cultural Diversity, Families, and the Special Education System: Communication and Empowerment,*New York: Teachers College Press.

This chapter, and book, are written explicitly about Spanish-speaking Puerto Rican families and their problems interacting with the "machine-bureaucracy" of the mainstream school system. However, it also provides an excellent discussion of some core issues involved in cross-cultural communications
with many mainstream human services systems, whether education, health
care, or social services. The chapter is divided into sections covering: **Trust Versus Deference, Written Communication, Information and Meaning, Resignation and Withdrawal,** and **Personalism, Professionalism, and Advocacy.** The author addresses the issue of "consent" which is often relinquished. The chapter explains how families often relinquish consent by default because they do not speak English, are intimidated by the system, or
may not comprehend the purposes and implicit rules of the system.

> *The problems . . . were not simply a matter of translation, of parents not knowing the English word for these activities: They did not know the Spanish name for them either. They did not know that they had a name at all. In other words, they did not realize that a particular activity or event as an established procedure, required by law, with a recognized name and a ritualized manner of implementation. Thus these parents had no context in which to evaluate the significance, indeed, the power, of these documents and*

proceedings in the lives of their children.

Harry, B., Allen, N., & McLaughlin, M. (1995, February). Communication versus compliance: African-American parents' involvement in special education. *Exceptional Children, 61* (4), 364-377.

The focus of this article is to help professional providers move from a preoccupation with parental compliance to true communication. Probably the greatest insight from this three-year study was the authors' finding that the burden of responsibility for increasing the participation of minority families in special education is most often placed on the shoulders of the parents. Professionals often couch this attitude in seemingly parent-friendly terms, such as "lack of knowledge of their rights or of system procedures and policies; difficulties with transportation, child care, or work." The authors found that the system helps cause, or at least perpetuate, this situation. It does this by showing "disrespect for the mothers' views, a focus on the deficits of the children, and a consistent discounting of the cultural differences that characterized these mothers' parenting styles." The authors discuss five aspects of professional behavior that are deterrents to parents' participation and advocacy:

1. Late notices and inflexible scheduling of conferences;
2. Limited time for conferences;
3. Emphasis on documents rather than participation;
4. The use of jargon; and
5. The structure of power.

These behavioral deterrents result in growing disillusionment and decreasing participation from parents who initially were satisfied with the placements and had expressed positive expectations in the process.

Hartog, J., & Hartog E. A. (1983, December). Cultural aspects of health and illness behavior in hospitals. *The Western Journal of Medicine, 139,*910-916.

After briefly stating the necessity for overcoming cultural barriers, the authors propose a set of six cautions. For example, "Intragroup individual differences may exceed intergroup differences," and "Ultimately, a good caring relationship can overcome any cultural misstep." General aspects of **Cultural Values** are discussed. Later the authors examine **Illness Behavior** in some

detail. They first look at individual behavioral variations. Then they examine more closely several kinds of culturally mediated behaviors, under headings such as: "Illness behavior determines who will agree to become a patient"; "Illness behavior determines how one behaves as a patient"; and "Culture influences who makes decisions about a patient's treatment." The next two main sections specifically address communication. **Communication in Hospital Settings** asserts that the hospital creates special problems because it is "so intrusive and so

many [practitioners] have access to patients." This is compounded by the "sense of strangeness and high anxiety connected with being in a hospital." The section on **Verbal Communication Problems** addresses three problem areas: the use of interpreters, English as a second language, and the "magical meaning of words." The final sections cover **Diet and Medication, Cultural Differences and Pain** , and **Religious Beliefs.**

Hyun, J. K., & Fowler, S. A. (1995, Fall). Respect, cultural sensitivity, and communication: Promoting participation by Asian families in the individualized family service plan. *TEACHING Exceptional Children, 28*(1), 25-28.

Although this article is aimed at improving communication between Asian American families and European American providers, it offers practical advice on cross-cultural communication. Under the heading **Enhancing cultural awareness,** the authors posit the need for improving the provider's own self-awareness as a first step toward better communication. They recommend that the provider begin by asking questions such as, "When I was growing up, what did my family say about people from different cultures?" They also suggest that professionals take the time to examine the various interpretations of seemingly common sayings, such as "Where there is a will, there is a way." Other sections of the paper include **Overcoming language differences--Obvious barriers to communication, Holding Effective Family Conferences,** and **Developing family outcomes in the IFSP.** The following "helpful strategies" for family conferences are good examples of advice that support the practice of family-centered, culturally competent care:

- Decide with the parents the time and location of the meeting and who will participate.
- Encourage parents to bring people who are important to them, such as relatives, friends, or religious leaders.
- Send a written notice of the meeting in the family's primary language.
- Determine whether the family need assistance with logistics, such as child care or transportation.

Joe, J. R., & Malach, R. S. (1992). Families with Native American Roots. In E. W. Lynch & M. J. Hanson (Eds.),*Developing Cross-Cultural Competence: A Guide for Working with Young Children and Their Families*(pp. 89-199). Baltimore: Paul H. Brookes Publishing Co.

This chapter is one of eight that covers specific "cultural groups." The other groups are Anglo-American, African American, Latino, Asian, Filipino, Native Hawaiian/Pacific Island, and Middle Eastern. The book also has an introductory section (see Lynch, below) and a concluding section. The authors have done an admirable job, given the necessity of generalizing about a cultural group that includes more than 500 distinct peoples with

different languages and cultural histories. The chapter begins with two narrative quotations reflecting a world view centered on generosity, balance, and cooperation. As with other chapters in this book, the authors follow a reader-friendly framework beginning with a **Background** section (Geography, History, Religion, and Language), followed by sections on **Contemporary life, Values, Beliefs, Issues of Language,** and **Summary and Recommendations.** At the end of the chapter is a reference list and three appendices covering: 1) Contrasting Beliefs, Values, and Practices [contrasted with Anglo-American culture]; 2) Cultural Courtesies and Customs; and 3) Significant Cultural Events/Holidays/Practices.

Jones. D. A. (1994). The diversity of families. In T. L. Shelton & J. S. Stepanek (Eds.) *Family-Centered Care for Children Needing Specialized Health and Developmental Services (3rd ed., pp 38-50).* Association for the Care of Children's Health, 7910 Woodmont Ave., Suite 300, Bethesda, MD 20814.

This chapter places diversity and the "cultural competence" of professionals within the context of family-centered care. It accentuates the role of families as carriers and protectors of culture, and as vehicles for the acculturation and socialization of each succeeding generation. "The family both shapes culture and is shaped by culture. Culture serves as a mitigating force, a kind of shock absorber, between the family and the world." The author describes how culture "provides families with a variety of ways of coping with the world," and "plays a strong role in defining the structure and function of the family itself." The author then describes ways in which culture "colors and flavors" the primary functions of the family in nourishing, protecting, and socializing the growing child. These primary functions are: *food, shelter, relationship, physical growth, intellectual growth, emotional growth, and spiritual growth.* These functions determine the norms for interaction and communication considered acceptable for family members. "What are their specific roles in the family?" "What rules will guide their behavior (deference to age and authority, how close to stand to each other, how much touching is allowed,

meaning of eye contact, volume of speech, value placed on vocal interchange,)?" "Is greater value placed on individuality, or on group cohesiveness (family/clan/community)?" "How will pain be perceived? Will suffering be expressed or repressed?"

Kleinman, A., Eisenberg, L., & Good, B. (1978, February). Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine 88,* 251-258.

Arthur Kleinman was one of the first physicians to advocate using the social sciences, particularly cultural anthropology, in clinical practice. In this seminal 1978 article, he and his co-authors argue that the purely biomedical approach to illness is too sterile. It has

brought health care to an impasse, unable to address such major problems as patient dissatisfaction, inequities in access to care, and upwardly spiraling costs. The authors exhort practitioners to free themselves from "ethnocentric and medicocentric views," and to begin to recognize issues that have been "systematically ignored." They distinguish between the *illness* of the individual (suffering that is individually perceived and culturally shaped) and the *disease* (biological condition affecting the human organism). It is the*disease* that has been the overwhelming focus of the mainstream health care system. They argue that medical research and clinical training have virtually ignored the healing of persons. All attention has been concentrated on the recognition and curing of specific disease entities. They argue forcefully for allocating the necessary resources to further research on the cultural effects of health and illness on the individual. They also support the development of curriculum and training for physicians which focuses more on the effects of illness on the individual and the healing of the individual, rather than the identification and treatment of disease.

Kreps, G. L., & Kunimoto, E. N. (1994). *Effective Communication in Multicultural Health Care Settings.* Thousand Oaks, CA: Sage Publications.

The third volume in this series, **Communicating Effectively in Multicultural Contexts** , presents the reader with an exhaustive, academic reading of the subject. It provides theory, research, case histories, and the authors' recommendations for effective communication strategies. This work includes seven chapters. The first chapter presents an overview. The final chapter provides an extensive list of guidelines summarizing the preceding chapters. Some chapters are quite unique, such as Chapter 4, **Communicating in multi-cultural groups in health care.** This chapter covers ethics committees and social support groups. Likewise, the fifth and sixth chapters deal with

organizational issues such as "Internal and external organizational communication," "Weick's model of organizing and cultural diversity," and "The strategic health communication campaign model." All chapters are subdivided into specific topical sections. Ten pages of references, an author index, and a subject index complete the book. This is a work for the serious student of cultural issues in health care delivery, or as a reference for the clinical administrator or diversity specialist.

Lipson, J. G., & Meleis, A. I. (1983, December). Issues in health care of Middle Eastern patients. *The Western Journal of Medicine, 139*(6), 854-861.

Because of deep political, cultural, and religious differences, probably no other group is perceived so much as mysterious "other" by the American mainstream as are the peoples from the *Middle East.* This article points out some real differences between the many national, social, and religious groups that make up the Middle East. For example, there are differences between Arab countries and Iran, whose inhabitants share the Moslem religion but speak Farci (Persian), not Arabic. However, the article mainly addresses those generally shared cultural attributes of the region that differ from the American mainstream and often create communication problems in the health care setting. The authors particularly considered those families visiting or recently immigrated from their home countries. These families have had little time to assimilate to American ways. Although the article's 1980 publication dates some material (e.g., listing one million Arabs in the U.S. population, "90% of whom are Christians"), most of the information is relevant. It addresses specific interactional issues likely to arise in the therapeutic setting. The sections on **Context, Time and Space; Interactional style;** and **Health and illness behavior,** are especially rich with concrete examples of obstacles to good communication and ways to overcome them.

Lynch, E. W. (1992). Developing cross-cultural competence. In E. W. Lynch & M. J. Hanson (Eds), *Developing Cross-Cultural Competence: A guide for Working with Young Children and Their Families* (pp. 35-62), Baltimore: Paul H. Brookes

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"Achieving cross-cultural competence requires that we lower our defenses, take risks, and practice behaviors that may feel unfamiliar and uncomfortable. It requires a flexible mind, an open heart, and a willingness to accept alternative perspectives." Thus begins Chapter 3 in this well-received book (see also Joe

and Malach, above). The chapter is divided into three sections: **Self-awareness; Culture-specific awareness and understanding;** and **Cross-cultural communication.** This last fifteen-page section is divided into topical areas:

- General principles of effective cross-cultural communication;
- General characteristics of effective cross-cultural communicators; and
- Working with interpreters and translators.

The author provides a useful list of qualities that describe the provider who is an effective cross-cultural communicator. It is a person who:

- Respects individuals from other cultures, and makes continued and sincere attempts to understand the world from others' points of view,
- Is open to new learning, flexible, and tolerates ambiguity well,
- Has a sense of humor, and approaches others with a desire to learn.

Muecke, M. A. (1983, April). Caring for Southeast Asian refugee patients in the USA. *American Journal of Public Health, 73*(4), 431-438.

This article was written to address problems in health care delivery to the "second wave" of Southeast Asian refugees (after 1975). These individuals are less educated, less familiar with Western ways, and typically spent several years in refugee camps. The author points out that "Although the refugees have only three national origins [Laos, Cambodia, and Vietnam], they represent a wide variety of ethnic, language, and religious groups." Sections of the article include: **The first encounter, Interpreters, Informed consent, The passive obedient patient, The non-compliant patient, Constraints of body image, Social supports, Medication, Traditional self-care practices,** and **Death and depression.** The author uses tables to demystify the geographic, ethnic, language, and religious roots of these groups, and to help providers understand the naming system of each ethnic group. This latter point is important because the Lao are the only Southeast Asian ethnic group that places the surname (family name) last, like most American ethnic groups. From the author's own experience and observations, she suggests that "A quiet, unhurried but purposeful demeanor is a part of normal professional decorum that is particularly reassuring to Southeast Asians because it symbolizes

characteristics that are highly valued among them, such as wisdom, good judgment and dignity."

Pachter, L. M. (1994, March 2). Culture and clinical care: Folk illness beliefs and behaviors and their implications for health care delivery. *Journal of the American Medical Association, 271* (9), 690-694.

This article describes the dynamics of communication between the provider and the individual/family as an interaction of two "cultures" -- the culture of medicine and the individuals served. The author argues that medical personnel share common experiences, specific codes of conduct, rules for communicating among themselves, and acceptance of a corpus of knowledge based on a common belief in the biomedical model of illness. Most people on the other hand, come to the therapeutic setting with a complex array of "personal experiences, family attitudes, and group beliefs" which interact to give them a decision-making model for understanding and treating illness. The article presents examples of "folk illnesses" which have no biomedical identified cause. The author argues that more satisfying provider-family relationships and better health outcomes will result from a basic knowledge of these folk illnesses, a willingness to listen carefully, and an ability to question sensitively the individual/family's beliefs about the illnesses.

Putsch, R. W., III (1985, December 20). Cross-cultural communication: The special case of interpreters in health care. *Journal of the American Medical Association, 254* (23), 3344-3348.

This succinct article represents a classic survey of the special problem of using language interpreters in the health care setting. An introduction reminds the reader of the importance of language in conveying information and emotion. The author then provides an overview of the field. Under the headings **Institutional accommodations to interpretation problems** and **The changing status of language-related health care problems,** the author offers a sense of how far medical interpretation has come, legally and institutionally. **Medical interpretation**

covers the expectations and intricacies, advantages and pitfalls, of using medical interpreters. **Selected issues and problems in medical interpretation** includes subsections on "Bad paraphrasing," "Interpreter-patient interactions," "Linguistic equivalency and training," "Interpreter beliefs and patient interactions," "Interpretation roles," "The interpreter's self-image, "Ethnocentric expectations," and "Special problems in mental health." These subsections provide poignant real-case examples. Using these examples the author shows how medical interpretation can go wrong--sometimes humorously, sometimes frighteningly. The **Conclusion** section includes simple and practical checklists under three headings: "General guidelines for monolingual providers in a cross-cultural environment," "Guidelines for provider-interpreter-patient interactions," and "Guidelines for language use in interpreter-dependent interviews."

Vincent, L. J. (1992, Spring). Families and early intervention: Diversity and competence. *Journal of Early Intervention, 16*(2), 166-172.

This article is taken from a keynote address delivered at the Annual Conference of the Division for Early Childhood, Council for Exceptional Children, on November 14, 1991. The author challenges providers in the newly developing early intervention field not to get too caught up with "professionally generated concerns." She recommends instead that they listen to families and communities to find out what they need and want for their children. She describes her efforts in Los Angeles to develop surveys and focus groups to "give families a chance to tell their stories." By listening to families, she learned that they are not interested in "curriculum models, or personnel standards, or developmental vs. functional . . ." They want information and support as parents. They also wanted socialization skills for their children, and help in the transition to new levels of independence. "Families particularly noted the importance of their relationship with a paraprofessional who spoke their language and came from their culture, especially when the professional staff did not." The glue for all these issues is communication -- with professionals, paraprofessionals, and other families.

Voelker, R. (1995, June 7). Speaking the languages of medicine and culture. *Journal of the American Medical Association, 273*(21), 1639-1641.

As the United States becomes more diverse, health care preservice and inservice education programs have begun to add training in transcultural aspects of health care delivery. Immigrant and refugee populations present a special set of issues, and are the focus of this article, aimed primarily at physicians. The author draws examples from large urban teaching hospitals such as Seattle's Harborview Medical Center and the Indiana University School of Medicine. Examples of recommended approaches for physicians include:

- Developing a knowledge base of health care beliefs and behaviors.
- Increasing understanding of "the history, culture, and psychosocial environment of patients' homelands."

- Recognizing the need for special help, such as well-trained interpreters.
- Understanding the uniqueness of each clinical encounter.
- Recognizing that when racial and ethnic aspects are added the physician must rely on "respect, empathy, understanding, and patience."

Woloshin, S., Bickell, N. A., Schwartz, L. M., Gany, F., & Welch, H. G. (1995, March 1). Language barriers in medicine in the United States. *Journal of the American Medical Association, 273* (9), 724-728.

The authors of this definitive article are successful in thoroughly updating our knowledge and understanding of the need for, status of, and the many pitfalls in using interpreters in the health care setting. They base their review on current statistics, such as the fact that almost 14 million people now living in the United States have poor English-language skills. A general survey of the field follows, again offering shocking facts: New York City, although it has one of the largest populations of limited English speakers in the nation, does not employ professional medical interpreters in its public hospital system. The authors then describe the three typical -- though much less than optimal -- methods used by providers and families to communicate in the clinical setting:

- Their own language skills;
- The skills of family of friends;
- Ad hoc interpreters (bilingual strangers from the waiting room, or employees like a clerk, aid, or custodian called away from regular job responsibilities to be an interpreter.

The authors describe how things can sometimes go wrong. They review the status of current state and federal laws. The article suggests ways for improving the state of interpreter services to assure the provision of optimal health care.

Yacobacci-Tam, P. (1987, September). Interacting with the culturally different family. *Volta Review, 89* (5), 46-58.

This thorough essay covers many aspects of transcultural communication and draws from well-cited sources. It discusses the cultural touch-points of mainstream American culture: achievement, competition, pragmatism, materialism, causality, logic, goal orientation, low tolerance of ambiguity, scientific rationalism (secular orientation), and time orientation. Looking at the communication process, we are reminded that mainstream Americans place high value on an internal locus of control and usually communicate in a linguistically sequential manner. The parameters of the verbal interchange are discussed under the headings **Semantics, Etiquette,** and **Resolution.** The author includes a discussion of low context communication: "Individuals in American society rely more heavily on the

auditory/verbal message, often ignoring . . . what is seen or unconsciously felt. Nonverbal cues are generally not experienced as a major avenue for getting or substantiating . . . meaning . . . ." The American style also dictates that "events are usually verbalized in terms of their cause-effect relationships, their priority in order of event, and their place within a culturally determined lexicon." The author discusses non-verbal aspects of communication, under the headings **Environment, Body awareness,** and **Social attitude.**

Video tapes

Cosgrove, K., & Edelman, L. (Producers). (1991). *Delivering Family-Centered, Home-based Services.* Office for Community Program Development (Project Copernicus), Kennedy Kreiger Institute, 2911 E. Biddle St., Baltimore, Maryland 21213. (410) 550-9700.

This training video includes five dramatized vignettes involving encounters between providers and families within their homes. It is designed so a facilitator can show a vignette, stop the tape and discuss what happened in the interaction. Then the facilitator can show a follow-up discussion between the filmed participants themselves (who are played by real families interacting with nurses, social workers, and therapists). They discuss what they think went wrong and what might have worked better. Two of the vignettes involve cross-cultural interactions. All of the scenarios are thought provoking. Before the vignettes begin, the narrator discusses a set of basic principles for delivering effective home-based services. These principles are:

- Respect for the family's values,
- Recognize that you are a guest,
- Trust the family,
- Work together with the family,
- Be flexible,
- Relate to families as people (not "patients"),
- Look at the whole picture,
- Recognize parents as the decision makers, and be creative.

This video tape is 52 minutes long.

May, J. (Producer). (1996). *Equal Partners: African American Fathers and Systems of Health Care.* National Fathers Network, Kindering Center, 16120 N.E. 8th Street, Bellevue, Washington 98008-3937. (206) 747-4004 Ext. 218 or (206) 284-2859.

Equal Partners provides a glimpse into the experiences of African American fathers who have children with special needs. We follow them with their children through clinic interviews, hospital visits, everyday home care, and outdoor excursions through the streets of the inner city. Other segments show these dads participating in father support groups, or responding directly to the camera about the unique challenges they face trying to work with health care delivery systems. The images are strongly positive, but often heart wrenching.

As one father sits in a clinic with his son on his lap, he tells us, "If I don't bring him here, he won't get here. If I don't bring him to the clinic, he won't make it." As tears begin to come his son, who has sickle cell anemia, gently touches his father's face. The father states, "It's just hard, that's all. Sometimes, a person just needs support. Without support, a person just won't make it." In another scene, a father expertly caring for his daughter states with pride and conviction, "Her body is disabled, but her heart is not disabled, her mind is not disabled. I try to give her the love and special attention that she needs." This video tape is 25 minutes long and comes with a discussion and resource guide.

Southwest Communication Resources, Inc. (1989). *Finding the Balance.*
P.O. Box 788, Bernalillo, New Mexico 87004. (505) 867-3396.

Finding the Balance presents the perspectives of two American Indian mothers about the diagnosis and treatment of their children with special needs. Although both mothers share their experiences as parents of children with disabilities, their perspectives are very different. One mother describes herself as an urban Indian. She discusses the conflicts her family experiences because her family is more modern in their beliefs, while her husband's family is more traditional. She also talks about the distance she feels from her culture and family support systems. The second mother lives in a rural reservation area, and follows traditional beliefs and lifestyle. Her culture and family provide a strong support system for her. She talks about how her family sought to find a balance between traditional medicine and modern medicine. Each viewer of this video may interpret what they see and hear differently, based on their own personal experiences and cultural values. The video's purpose is to improve cross-cultural communication by increasing the viewer's understanding of the needs and viewpoints of American Indian parents. The video tape is 23 minutes long.

Southwest Communication Resources, Inc. (1990). *Listen With Respect.*
P.O. Box 788, Bernalillo, New Mexico 87004. (505) 867-3396.

This video tape presents an overview of the cross-cultural barriers encountered by many American Indian parents and health care providers. It presents a dramatic scenario in which a physician and an Indian family are trying to communicate, but with less than satisfactory results. The video explains the reasons why miscommunication may occur when the health care provider and family have different cultural backgrounds. It shows how important it is for providers to learn about the cultural and communication styles of families. Although the focus is on American Indian families, particularly those of the Southwest, several key points which are relevant to many cultures are discussed. These include the important role played by extended family members, the importance of traditional healing methods, and the need for time to build a trusting relationship with health care providers. This is a good video tape for introductory level training. The video tape is 17 minutes long.

Journals & On-Line Resources

Tao K-G (Ed.). (1995). Ethnic Medicine Guide [Internet: http://www.hslib.washington.edu/clinical/ethnomed]. Seattle: Harborview Medical Center, University of Washington.

EthnoMed is a World Wide Web "home page" on the Internet developed by faculty and staff of the Children's Clinic at Harborview Medical Center in Seattle. The Clinic "serves an urban patient population, with many immigrants and refugees from southeast Asia and Africa." EthnoMed is designed to be an easy-to-use clinical tool for physicians, nurses, and social workers. It is based on concise practical information and is structured on a standardized template. This template consists of a "profile of each ethnic group [covering] community issues, monographs, cultural topics, symptoms and diseases, along with further reading, links to other Web sources, and patient education materials." Presently, this Website concentrates on refugee immigrants to the Seattle area, including (at the time of this writing) ethnic groups from Southeast Asia and the Ethiopian/Somalian region of Africa: Amharic, Cambodian, Eritrean, Oromo, Somali, Tigrinean, and Vietnamese. The person looking to bridge communication issues will be interested in topics covering **Language, Etiquette** ("Greetings," "Social distance," and "Displays of respect"),**Family Life** (especially, "Gender, Status and Age relationships"),**Traditional medical practices,** and **Experience with Western medicine in the United States.**

Journal of Cross-Cultural Psychology. Sage Periodicals Press, SAGE Publications, Inc., P.O. Box 5084, Thousand Oaks, California 91359. (805) 499-0871.

This journal provides a scholarly forum for professionals "who study how cultural differences in developmental, social, and educational experiences affect individual behavior." Recent articles include "Cultural Influences on the Recognition of Emotion by Facial Expressions," "Acculturation and Stress: Vietnamese refugees in Finland," and "Culture, Self-Construal, and Embarrass-ability." Bi-monthly. Individual subscription: $62 per year.

Journal of Cultural Diversity. Tucker Publications, Inc., Box 580, Lisle, Illinois 60532. (708) 969-3809.

This journal is for "educators, researchers and practitioners involved in all areas of cultural diversity and the delivery of care, the development and implementation of programs, the formulation of policies, and the pursuit and analysis of research." Articles have included "Perceptions of African American Women Regarding Health Care," and "A Culture of Diversity: One Agency's Model." Quarterly. Individual subscription: $25 per year.

Journal of Health Care for the Poor and Underserved Institute on Health Care for the Poor and Underserved, Meharry Medical College, 1005 D.B. Todd Blvd., Nashville, Tennessee 37208. (615) 327-6819, or (800) 669-1269.

This journal "publishes original papers, guest editorials, brief communications, and reviews on issues related to the health of, and health care for, low-income and medically underserved people." Although primarily an academic research forum, this journal also includes brief communications, book reviews, and discussions. One issue each year contains the Proceedings of the Annual National Conference on Health Care for the Poor and Underserved. Some past themes were "Targeting the Needs of the Underserved: The Urgency of Health Care Reform," and "Managed Care: Ensuring Equity for the Underserved." Quarterly. Individual subscription: $35 per year.